

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-017624

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

317  
FILED APR 27 1962

Primary Registration District No.

546

Registrar's No.

1146

VS 300  
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Overland</u>		c. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Overland</u>	
Length of stay in 1b <u>10 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2239 Woodson Road</u>		d. STREET ADDRESS (If outside, give location) <u>2239 Woodson Road</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Calvin</u> Middle <u>Anderson</u> Last <u>Warren</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/93</u>
9. AGE (last birthday) <u>68</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (City and state or country) <u>Terre Haute Indiana</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Amos T. Warren</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Kusick</u>	
14. NAME OF HUSBAND OR WIFE <u>Mamie Warren</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Mamie Warren 2239 Woodson Road</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion</u> DUE TO (b) <u>Cirrhosis of Liver</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>March 62 Death</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	
20g. COUNTY <u>Missouri</u>		20h. STATE <u>Missouri</u>	
21. I attended the deceased from <u>March 62</u> to <u>March 62</u> and last saw him alive on <u>11 April 1962</u> Death occurred at <u>340</u> on the date stated above, and to the best of my knowledge from the causes stated.		22. SIGNATURE <u>Paul R. Whitener</u> (Degree or title) <u>M.D.</u>	
22b. ADDRESS <u>892 Midland, St. Louis (14) Mo</u>		22c. DATE SIGNED <u>12 April 1962</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/13/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri</u>
24. FUNERAL DIRECTOR <u>Shepard Funeral Home 1167 Hamilton Ave</u>		25. DATE RECEIVED BY LOCAL REG. <u>4-12-62</u>	
26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>			

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

\_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

**Signature of Student Embalmer**

**Signed**

Licensed Embalmer No. 7979

P. O. Address Berkeley 37, 1/2

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.